CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

HIV/AIDS PREVENTION

Working to prevent HIV infection and reduce associated illness and death

March 1997

De Cock, Holtgrave Named Directors of New Divisions of HIV/AIDS Prevention

Dr. Helene Gayle, Director of the National Center for HIV, STD, and TB Prevention (NCHSTP), has announced the appointment of new directors for the two Divisions of HIV/AIDS Prevention.

David R. Holtgrave, Ph.D., has been named to head the Division of HIV/AIDS Prevention—Intervention Research and Support (DHAP-IRS) and Kevin De Cock, M.D., F.R.C.P., will lead the Division of HIV/AIDS Prevention-Surveillance and Epidemiology.

Dr. David Holtgrave

Dr. Kevin De Cock

Dr. Holtgrave comes to DHAP-IRS from the Center for AIDS Intervention Research, Department of Psychiatry and Behavioral Medicine, at the Medical College of Wisconsin, where he serves as Associate Professor of Psychiatry and Behavioral Medicine, Associate Center Director for Programs, Director of Cost-Effectiveness Studies Core, Director of AIDS Policy Studies, and Co-Director of the Post-doctoral Training Program. Prior to that, from 1993 to 1995, he was at CDC in the Office of the Director, serving as Acting Assistant Director for Behavioral Science in the Office of the Associate Director for HIV/AIDS. He first served at CDC as a behavioral scientist in the Office of the Deputy Director for HIV, National Center for Prevention Services, from 1991 to 1993.

Dr. Holtgrave received a bachelor degree in psychology from the University of Missouri at St. Louis in 1983 and his Ph.D. from the University of Illinois at Urbana/Champaign with a major in quantitative psychology and split minor in experimental and clinical psychology.

Dr. Holtgrave was awarded the *C. Everett Koop National Health Award* in 1996, a U.S. Public Health Service *Special Recognition Award* in 1995, and numerous CDC awards. He is listed in the *Who's Who Among Human Services Professionals* (1992-93 edition). He is a member of numerous professional societies and has written or co-authored more than 70 journal articles and other publications.

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On the inside...

Think TB!

"The growing epidemic of HIV has breathed new life into an old enemy—tuberculosis. The HIV epidemic spurs the spread of TB and increases the tuberculosis risk for the whole population. For those who are HIV-positive, the TB risk is especially great and the outcome often fatal."

—UNAIDS

(See related article, page 10)

Note from the editor...

CDC is aware that the December newsletter reached most readers too late for them to participate in numerous special World AIDS Day events that were publicized in that issue. The *CDC HIV/AIDS Prevention Newsletter* staff sincerely regrets any inconvenience this may have caused. We are working very hard to ensure that the production problems (both human and mechanical) that contributed to the publication delay in December do not recur, and we hope that you continue to find the newsletter useful in your HIV/AIDS prevention activities.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Centers for Disease Control and Prevention •
National Center for HIV, STD, and TB Prevention • Divisions of HIV/AIDS Prevention

Upcoming Conference on Women and HIV

The National Conference on Women and HIV—Innovation for Care, Policy and Prevention will be held May 4-7 at the Pasadena Convention Center in Los Angeles, California.

The conference is intended to provide an interdisciplinary forum on the HIV epidemic among women. More than 1,500 scientists, community providers, women with HIV infection, and policy makers will discuss the latest developments in scientific research, HIV prevention, and clinical care.

CDC is a co-sponsor of the conference, along with the National Institute of Mental Health, California's Department of Health Services Office of AIDS, National Family Planning and Reproductive Health Association, and AIDS Project Los Angeles.

For further information, call the 24-hour conference hotline at **1-800- 845-2115**, or send an E-mail to **womenconf@aol.com**. On the Internet, the conference web site is located at **http://www.womenhivconf.com**. ⌘

National Conference on Women & HIV

Innovation for Care, Policy and Prevention

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DHAP-IRS provides national leadership in intervention research, technology transfer, technical support, program implementation, training, evaluation, and information dissemination for HIV/AIDS prevention. The Deputy Director is Mr. Gary West, who has served since October as Acting Director of DHAP-IRS while a national search was conducted for permanent leadership.

"Dr. Holtgrave has an extensive background in HIV prevention research with a particular focus on prevention effectiveness... and has played a major role in helping bridge the gap between prevention science and interventions," said Dr. Gayle.

Dr. De Cock joins the DHAP-SE staff from the London School of Hygiene and Tropical Medicine where he was a Senior Lecturer in the Department of Clinical Sciences for the last 4 years. He also held the appointment of Consultant Physician at the Middlesex Hospital, London. He began his CDC career in 1986 as an Epidemic Intelligence Service (EIS) officer with the Special Pathogens Branch, Division of Viral Diseases, National Center for Infectious Diseases. He later helped establish CDC's Projet RETRO-CI in Abidjan, Côte d'Ivoire, and he became the project's first Director in 1988, serving in that capacity until March 1993.

Dr. De Cock received his medical degree from the University of Bristol in 1974 and a Diploma in Tropical Medicine and Hygiene from the Liverpool University School of Tropical Medicine in 1979. He specialized in internal medicine and was elected to the Royal College of Physicians of the United Kingdom in 1977, becoming a Fellow of that organization in 1996. He has served since 1986 as a consultant to the World Health Organization on yellow fever, HIV/AIDS, and tuberculosis.

Dr. De Cock has received numerous awards, including the CDC and ATSDR *1992 Honor Award for International Health*; the *Commander of the Order of Public Health*, Côte d'Ivoire, 1993; and the *Chalmers Medal* (for contributions to tropical medicine research) from the Royal Society of Tropical Medicine and Hygiene, 1995. He is a member of numerous prestigious professional organizations and has written or co-authored more than 160 journal articles and other publications.

DHAP-SE provides national leadership in HIV/AIDS surveillance, statistics, and epidemiology for HIV prevention. The Deputy Director is Dr. Robert Janssen, who has served as Acting Director of DHAP-SE since October.

"Dr. De Cock is internationally renowned as an HIV/AIDS researcher and brings a wealth of experience in international public health and HIV clinical care," Dr. Gayle said.

The new division directors are expected in Atlanta to take up their duties full time by mid-summer. ⌘

CDC HIV/AIDS PREVENTION

Intermittent publication for constituents of the Centers for Disease Control and Prevention (CDC), Public Health Service, U.S. Department of Health and Human Services

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CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Public Health Training Network

Satellite Broadcast:

"HIV Prevention Update — Key Issues in Counseling and Testing"

Date: May 22, 1997
Time: 1:00-3:30 PM EST

Presented especially for –

- ☞ Staff at HIV counseling and testing sites, both public and private
- ☞ HIV prevention providers, such as HIV Prevention Community Planning Group members, educators, trainers, administrators

Objective: To provide information on and explore the programmatic implications of counseling issues and new testing technologies

Speakers: Members of the CDC research staff and the National Alliance of State and Territorial AIDS Directors

Viewing Sites:

This program will be available on C and Ku-bands. Locate a satellite down-link site with a steerable antenna that can receive either C or Ku-band channels. Your organization may have such a viewing site, or you may contact schools, hospitals, community colleges, universities, or county extension offices to request use of their viewing site. A telephone or fax machine near the viewing room will allow for interaction with the speakers during the program.

Registration:

After April 15, you may

- ☞ receive a fact sheet with more information (including satellite coordinates) by fax. Call (toll free) 1-888-CDC-FAXX (232-3299) and, when asked, enter document number 564029. You will then be asked to enter your fax number.
- ☞ register for this program by calling the CDC National AIDS Clearinghouse at 1-800-458-5231.

Broadcast sponsored by CDC's National Center for HIV, STD, and TB Prevention, CDC's Public Health Practice Program Office, and the Public Health Training Network

Reasons for hope and concern

Implications of Recent Treatment Advances

The Food and Drug Administration recently approved three new compounds in a new class of drugs, called protease inhibitors, to treat HIV infection. These drugs, when taken in combination with previously approved drugs such as zidovudine (AZT) and lamivudine (3TC), reduce the level of HIV particles circulating in the blood (viral load) to very low levels in many individuals. These results are extremely encouraging, and these drug combinations are more effective than any previously available therapies. Researchers are hopeful that this type of combination therapy, with further study, will prove effective long term and increase the healthy life span of HIV-infected people.

Yet it is premature to declare victory over AIDS. There remain several areas of uncertainty and reasons for caution. The following information highlights these areas.

Long-term Effectiveness and Safety Are Unknown

• The new combination therapies reduce the concentration of HIV particles circulating in the blood of most individuals, but there is no evidence that they completely eradicate the virus from all parts of the body. HIV may rebound from such areas as the lymph nodes, brain, or white blood cells.

• It is not known how long these drugs will be effective in maintaining reduced levels of HIV in the bloodstream. Few patients have been studied for longer than 2 years.

• These drugs do not work for all people. In some individuals, substantial levels of circulating virus persist despite their taking the newer drug combinations.

• Many patients have serious side effects which prevent them from taking the drugs. Moreover, the long-term health consequences of taking these drugs for many years are unknown.

• These drugs are extremely expensive (approximately $12,000 per year), and many infected persons in the United States will not be able to afford these therapies.

• Because of the prohibitive costs, these therapies will simply not be available in developing countries where more than 90 percent of new HIV infections are occurring. Fighting the epidemic globally will require more cost-effective solutions.

• These drugs will be added to the long list of drugs AIDS patients often take, and protease inhibitors have complex interactions with many of these drugs. In particular, there are serious problems with taking protease inhibitors in conjunction with drugs commonly used to treat TB. Physicians prescribing these drugs must carefully consider all potential interactions.

HIV Can Develop Resistance to Each of the New Drugs

The new combination therapies require patients to follow complex treatment regimens, taking multiple medications several times each day. Some must be taken with food, and some must be taken on an empty stomach—and these drugs may have to be taken for the rest of the patient's life.

People who miss doses of their medication may be at increased risk for developing drug-resistant strains of HIV. If these strains are transmitted to others and spread widely, HIV infection could become again more difficult to treat.

Persons at Risk May Be Misled into Reverting to Unsafe Behaviors

CDC has received anecdotal reports that some people at high risk for infection may be interpreting the new treatment advances as a "cure." Moreover, they may falsely believe that HIV-positive individuals taking protease inhibitors are not infectious. As a result, some people may believe there is no longer a need to avoid high-risk sex and drug use. CDC is concerned that people may be placing themselves at unnecessary risk because of these misconceptions. CDC also is concerned that the transmission of resistant strains could undermine the benefits of treatment advances.

There is no evidence to date that new therapies provide any protection against HIV transmission. For sexually active people who are not in a monogamous relationship with an uninfected partner, the consistent and correct use of a condom with each act of intercourse is still the most important means of prevention. For drug users who continue to inject drugs, a sterile syringe should be used for each injection.

Prevention Remains the Best Solution

Prevention remains our best and most cost-effective approach for bringing the HIV/AIDS epidemic under control and saving lives. As we continue to work to develop better treatment options, we must not lose sight of the fact that preventing HIV infection precludes the need for people to undergo complex, costly treatment regimens. We must maintain a strong foundation of behavioral interventions and, at the same time, focus on developing and strengthening biomedical prevention interventions such as vaccines, microbicides, and the treatment of other STDs. We also must assess the emergence of drug resistance and the impact treatment messages may have on people's adoption or maintenance of protective behaviors.

In recent years, there has been a great deal of progress made in both

(See Treatment Options, next page)

AIDS Deaths Decline While Decreases Are Noted in Perinatally Acquired Cases

As reported in the February 28 issue of the *Morbidity and Mortality Weekly Report*, for the first time in the epidemic there has been a marked decrease in deaths among people with AIDS. The report noted a 13 percent decline in the number of estimated AIDS-related deaths in the first two quarters of 1996 as compared with the first two quarters of 1995.

The *MMWR* also reported that the estimated number of people diagnosed with AIDS each year (AIDS incidence) continued to slow, with an increase of only 2 percent in 1995.

The decline in AIDS-related deaths is likely due to both the slowing of the epidemic overall and the improved treatments over the past several years that have lengthened the life span of people with AIDS.

Researchers noted that the good news is tempered by ongoing prevention challenges. Deaths have *not* declined among women or among heterosexuals. While deaths declined among men by 15 percent, they increased among women by 3 percent. In addition, although decreases were noted among men who have sex with men (18 percent) and injecting drug users (6 percent), AIDS-related deaths among heterosexuals increased 3 percent.

The MMWR also described continuing trends reflected by AIDS cases reported in 1996:

- In 1996, for the first time, blacks accounted for a larger proportion of AIDS cases (41 percent) than whites (38 percent).

- The proportion of AIDS cases among adult and adolescent females continued to increase. In 1996, women accounted for 20 percent of newly reported AIDS cases.

Additionally, the number of people living with AIDS continues to rise. Between mid-1995 and mid-1996, AIDS prevalence increased 10 percent. As of mid-1996, an estimated 223,000 people were living with AIDS (see chart below).

Perinatal AIDS Declines

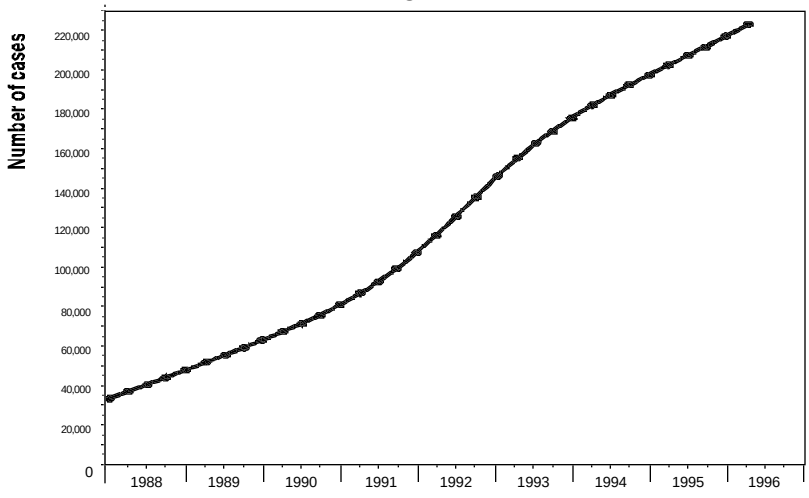
CDC also reported recently (in the November 22 issue of the *MMWR)* that the estimated number of perinatally acquired AIDS cases declined 27 percent from 1992 to 1995, from 905 to 663. The *MMWR* report states that because the number of HIV-infected women who gave birth each year was stable during 1989-1994, this decline suggests that the decrease in perinatal HIV transmission rates probably reflected the effect of perinatal zidovudine therapy. Increasing proportions of women may be accepting voluntary prenatal HIV testing and using zidovudine to prevent perinatal transmission. However, because the incidence of perinatally acquired AIDS declined slightly before the U.S. Public Health Service recommendations on zidovudine therapy were issued in 1994, other factors also may have contributed to the decrease in perinatally acquired AIDS cases during this period. For example, the proportion of HIV-infected childbearing women who received zidovudine therapy before and during pregnancy for treatment of their HIV disease was increasing at the same time. Among children, increased use of prophylaxis to prevent opportunistic infections may have delayed the development of these conditions.

For further reading...

AIDS Among Children—United States, 1996. *MMWR* 1996, Volume 45, Number 46, pages 1005-1010

Update: Trends in AIDS Incidence and Prevalence—United States, 1996. *MMWR* 1996, Volume 46, Number 8, pages 165-173 ⌘

Estimated AIDS Prevalence* in the United States, 1988 through June 1996



*Number of prevalent AIDS cases among persons age 13 or older, adjusted for delays in reporting, by quarter year.

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HIV prevention and treatment. Addressing these issues will be critical to maintaining and building upon these advances. CDC is developing systems to monitor high-risk behavior and to watch for the transmission of drug-resistant HIV strains, and is working with communities to continually improve HIV prevention programs and make them available to people at risk. ⌘

NIH Hosts Consensus Development Meeting, Issues Report on Conclusions and Recommendations

The National Institutes of Health sponsored a conference in Bethesda, Maryland, February 11-13 to examine what is known about behavioral interventions that are effective with different populations in different settings for the two primary modes of HIV transmission—unsafe sexual behavior and unsafe drug injection practices.

The 3-day meeting brought together behavioral and social scientists, prevention researchers, statisticians and research methodologists, clinicians, physicians, nurses, social workers, mental health professionals, other health care professionals, and members of the public to discuss how to help people change their HIV-related risk behaviors. Presentations and discussions focused on the following five questions:

• How can we identify the behaviors and contexts that place individuals/communities at risk for HIV?

• What individual-, group-, or community-based methods of intervention reduce behavioral risks? What are the benefits and risks of these procedures?

• Does a reduction in these behavioral risks lead to a reduction in HIV?

• How can risk-reduction procedures be implemented effectively?

• What research is most urgently needed?

After an extensive review of the scientific literature including hundreds of studies, scientific presentations by 15 research experts, and public testimony, an independent, nongovernmental consensus panel weighed the scientific evidence and developed a draft consensus statement. The eight conclusions and recommendations, quoted from that report, are as follows:

1. Interventions are effective for reducing behavioral risk for HIV/AIDS. These interventions should be widely disseminated. Their application in practice settings may require careful training of personnel, close monitoring of the fidelity of procedures, and ongoing monitoring of effectiveness. Results of this evaluation must be reported; where effectiveness in field settings is reduced, program modifications must be undertaken immediately. The panel concluded that three approaches are particularly effective for [reducing] risk in drug abuse behavior:

• needle exchange programs

• drug abuse treatment

• outreach programs for drug abusers not enrolled in treatment

Several programs were deemed to be effective for [reducing] risky sexual behavior:

• [providing] information about HIV/AIDS and

• building skills to use condoms and to negotiate the interpersonal challenges of safe sex. Safe sex programs have been developed for men who have sex with men, for women, and for adolescents.

2. The epidemic in the United States is shifting to young people, particularly those who are gay and who are members of ethnic minority groups. New research must focus on these emerging risk groups. Interventions must be developed and perfected, and special attention must be given to long-term maintenance of effects. In addition, AIDS is steadily increasing in women, and transmission of HIV to their children remains a major public health problem. Interventions focused on their special needs are essential.

3. Regional monitoring of changes in behavioral risk is necessary to identify groups and geographical regions with special risk for seroconversion to HIV-positive status. The panel believes that this is a critical part of national strategy to contain the spread of HIV.

4. Preventive programs are essential for individuals already infected with HIV. Programs must be developed to help these individuals eliminate risky sexual and substance abuse behavior. This national priority will become more pressing as new biological treatments prolong life.

5. Legislative restriction on needle exchange programs must be lifted. Such legislation constitutes a major barrier to realizing the potential of a powerful approach and exposes millions of people to unnecessary risk.

6. Legislative barriers that discourage effective programs aimed at youth must be eliminated. Although sexual abstinence is a desirable objective, programs must include instruction in safe sexual behavior, including condom use. Such programs are discouraged by welfare reform provisions which provide support only for programs using abstinence as the only goal.

7. The erosion of funding for drug abuse treatment programs must be halted. Research data are clear that the programs reduce risky drug abuse behavior and often eliminate drug abuse itself. Drug abuse treatment is a central bulwark in the nation's defense against HIV/AIDS.

8. The catastrophic breach between the behavioral science of HIV/AIDS prevention science and the legislative process must be healed. Citizens, legislators, political leaders, service providers, and scientists must unite so that scientific data may properly inform legislative process.

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In the full consensus statement, the panel said that just as the Food and Drug Administration conditionally approves experimental drugs in emergency situations, the urgency of the AIDS epidemic justifies the need for implementing those behavioral intervention programs proven by rigorous scientific study to be the most successful.

The NIH Consensus Development Program was established in 1977 as a mechanism to resolve in an unbiased, impartial manner controversial topics in medicine and public health. In the past 20 years, the NIH has conducted more than 120 such conferences addressing a wide range of controversial medical issues important to health care providers, patients, and the general public.

The complete draft consensus statement is available on the Internet at **http://consensus.nih.gov.** ⌘

Recent JAMA Article Reports on National Survey of Laws and Regulations on Syringes and Needles

"Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users—A National Survey on the Regulation of Syringes and Needles" was published recently by researchers from the Georgetown/Johns Hopkins Program in Law and Public Health, the Harvard School of Public Health, and CDC. It appeared in the January 1 issue of the *Journal of the American Medical Association*.

In addition to reporting the results of a survey of laws and regulations governing the sale and possession of needles and syringes in the United States and its territories, the article discusses legal and public health proposals for increasing the availability of sterile syringes as a measure to prevent HIV transmission among persons who continue to inject drugs. The following approaches to HIV prevention are discussed:

• clarifying the legitimate medical purpose of sterile syringes for the prevention of HIV and other blood-borne infections

• modifying drug paraphernalia laws to exclude syringes

• repealing syringe prescription laws

• repealing pharmacy regulations and practice guidelines restricting the sale of sterile syringes

• promoting professional training of pharmacists, other health professionals, and law enforcement officers about the prevention of blood-borne infections

• permitting local discretion in establishing syringe exchange programs

• designing community programs for safe syringe disposal

The article was written by Lawrence O. Gostin, J.D.; Zita Lazzarini, J.D., M.P.H.; T. Stephen Jones, M.D., M.P.H.; and Kathleen Flaherty, J.D. To request a copy, call the CDC National AIDS Clearinghouse at 800-458-5231. (Ask for inventory number D435; one free copy per request.) ⌘

The JAMA article discusses legal and public health proposals for increasing the availability of sterile syringes as a measure to prevent HIV transmission among persons who continue to inject drugs.

AMA Develops Physician Guide

The American Medical Association (AMA), assisted by a grant from the Kaiser Family Foundation, recently mailed more than 220,000 copies of a new report, "A Physician Guide to HIV Prevention," to primary care physicians across the United States.

The *Guide* is not intended as a standard of care, but reflects the views of experts and the medical literature as of June 1996. It was designed by the AMA and its collaborating organizations to help practicing physicians in the United States apply HIV prevention principles during the provision of primary care. It helps physicians better understand HIV risk behaviors and the process of patient behavior change, suggests assessment techniques to identify patient risks, and provides tools for helping patients change their HIV risk behaviors and maintain a level of reduced risk.

In addition to a list of resources and references, the *Guide* includes discussions of the following:

• **HIV Prevention in Primary Care: Overcoming the Obstacles** covers such topics as the difficulty of knowing when a prevention intervention is appropriate, talking about sexual or drug-using behaviors that may make the patient uncomfortable, and time constraints on physicians.

• **Sex and HIV Prevention** describes sexual behavior and risks and suggests ways to help patients eliminate or reduce those risks, including how to instruct patients on correct condom use.

• **Injecting Drug Use and HIV Prevention** includes an excellent discussion of risk-reduction options for those who continue to inject drugs. Among other advice, the

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Guide urges primary care physicians to help their patients reduce HIV risk by encouraging them to "use a new needle and syringe each time drugs are injected" and to never share injection equipment.

• **HIV-Antibody Testing and HIV Prevention** tells physicians how to take advantage of the opportunities testing provides to discuss risk-reduction strategies with patients. It also discusses the advantages of HIV testing for pregnant women.

• **HIV Prevention Planning** provides a method of assessing and counseling patients for HIV risk.

CDC collaborated in compiling the report, along with the following organizations:

American Academy of Family Physicians

American Academy of Pediatrics

American College of Obstetricians and Gynecologists

American College of Physicians

American Osteopathic Association

American Society of Internal Medicine

Canadian Medical Association

Center for AIDS Prevention Studies, University of California, San Francisco

Gay and Lesbian Medical Association

Group Health Cooperative of Puget Sound

Interamerican College of Physicians and Surgeons

National Medical Association

Society for Adolescent Medicine

United Medical Group Association

If you would like a copy of the *Guide*, call the AMA at 312-464-5563. ⌘

Measuring the Acceptability of HIV Antibody Testing

"The Acceptability of Voluntary Human Immunodeficiency Virus Antibody Testing in the United States, A Decade of Lessons Learned," by CDC's Kathleen L. Irwin, M.D., M.P.H.; Ronald O. Valdiserri, M.D., M.P.H.; and Scott D. Holmberg, M.D., M.P.H., was published in the October 11, 1996, issue of the British journal **AIDS**. *The following information is summarized and/or excerpted from that article. You may find the journal* **AIDS** *at major public and college or university libraries; reprints are* ***not*** *available from CDC.*

HIV-antibody counseling and testing (CT) has become a cornerstone of comprehensive HIV prevention and treatment efforts in the United States. As of 1993, an estimated 6 million Americans had been tested in publicly funded settings, and millions more had been tested in the private sector. About 5 percent of U.S. adults have been tested voluntarily in hospitals, clinics, freestanding CT sites, physicians' offices, prisons, drug treatment programs, and community organizations. Although demand for CT has grown rapidly, an estimated 40 percent of Americans with HIV risk behaviors have never been tested.

As the benefits of early diagnosis of HIV infection increase, U.S. adults are more likely to be offered HIV counseling and testing in settings where they may not seek testing. However, rates and determinants of CT acceptance in these settings are

(See Counseling & Testing, next page)

Acceptance rates for voluntary HIV antibody testing among selected U.S. populations

Population	Number of studies	Number of persons offered testing	Acceptance rate (%)
Pregnant women	25	>174,412	3-100
Family planning clients	4	10,399	14-67
Gynecology patients	6	> 3,975	10-97
STD clinic clients	14	>13,500	29-92
Illicit drug users	6	> 1,903	38-85
Hospital patients	4	>29,600	11-91
Prison inmates	4	6,497	47-89
TOTAL	62*	>240,286	3-100

* Sum = 62 because one study reported rates in both pregnant women and family planning clients

NOTE: The studies in this review varied greatly in design, measurement of predictor and outcome variables, analysis, study populations, geographic area, generalizability, and time period. We therefore considered ranges of acceptance rates in different populations to be more meaningful than single summary measures such as means, medians, or point estimates derived from meta-analysis.

"From an individual perspective... voluntary testing is of limited value if clients do not learn their results, if the accompanying counseling is substandard, if the consent process is overtly or subtly coercive, or if CT does not result in behavior change."

Counseling & Testing... from page 8

poorly understood. Because clinicians, public health officials, patient advocates, prevention specialists, and health policy experts who are familiar with these issues can more critically develop, implement, and evaluate CT policy, increasing their understanding is very important. To this end, the authors reviewed articles and abstracts published from 1985 through 1995 that addressed rates or determinants of CT acceptance in facilities that provide perinatal, family planning, gynecologic, sexually transmitted disease (STD), and drug treatment services; hospitals; and prisons. Their findings reflect the testing experience of more than 240,000 adults.

Acceptance Rates Vary

Available data indicate that acceptance rates for voluntary CT by persons who do not specifically seek CT vary dramatically—from 3 to 100 percent—even within test settings of the same type (see chart at left). Although many groups have advocated the expansion of CT, high rates of acceptance, per se, are not inherently good from either an individual or a societal perspective.

From an individual perspective, accepting testing is merely one step in the CT process; voluntary testing is of limited value if clients do not learn their results, if the accompanying counseling is substandard, if the consent process is overtly or subtly coercive, or if CT does not result in behavior change.

From a societal perspective, increasing acceptance rates may detract from HIV prevention efforts if it shifts resources from high-risk or infected populations to groups who are at low risk for infection.

The decision to accept CT is complex and highly personal and is influenced by many client, provider, and program characteristics that involve balancing diverse concerns about risks and benefits. Other determinants of acceptance not addressed by the reviewed studies may also contribute to the wide variation in reported acceptance rates. Because no widely generalizable study has considered all possible predictors of acceptance and the interrelationships of these factors, it is impossible to determine which factors, independently, are the most important determinants of acceptance. In addition, the relationship of these characteristics undoubtedly changes over time and differs by program type, clients, locale, rationale, and context. Thus, CT program managers who wish to understand determinants of acceptance in their programs should consider both these general findings and program-specific evaluations.

Study Findings

Several factors appear to consistently increase acceptance rates:

• the client's perception of high risk for acquiring or transmitting HIV or acknowledgment of HIV risk behaviors

• the presence of strong confidentiality protections

• access to anonymous CT

• presentation of CT as "routine" rather than "optional"

• a counseling approach that clearly endorses the benefits of testing and highlights the integration of CT with clinical care

Factors that are consistently associated with lower acceptance rates include the following:

• prior HIV testing

• client's fears about coping with the adverse medical and psychosocial consequences of the test result, including discrimination resulting from potential confidentiality violations

• informed consent that explicitly states a person's right of refusal

Although many clinicians consider early intervention for HIV disease to be one of the most important benefits of CT, the researchers found only limited evidence that client awareness of the medical, psychological, and social benefits of early identification of HIV infection (for example, zidovudine treatment to reduce rates of perinatal transmission, new antiretroviral therapies, and more comprehensive social services) was associated with acceptance among the populations and time period covered by this review. Possible explanations may be that (1) people who do not specifically seek testing may have more limited awareness of such benefits than people who have sought CT; (2) some of the poor, marginalized populations considered in this review may experience barriers to accessing these benefits or question the value of these advances; and (3) many of the reviewed studies were conducted before such benefits were available. The absence of a clear trend of increasing acceptance as such benefits become more widely available in the 1990s suggests the latter explanation may be least important.

The findings from this study have several implications for counseling and testing programs in the United States:

(See Counseling & Testing, next page)

"From a societal perspective, increasing acceptance rates may detract from HIV prevention efforts if it shifts resources from high-risk or infected populations to groups who are at low risk for infection."

WHO Observes World TB Day on March 24

The World Health Organization's Global Tuberculosis Programme (GTP), in cooperation with the International Union Against TB and Lung Disease, sponsored the second annual observance of World TB Day on March 24. This date was the 115th anniversary of the 1882 discovery of the cause of tuberculosis.

The GTP estimates that 1 of every 3 people on earth is infected with *Mycobacterium tuberculosis*, the bacteria that can lead to TB. Prevalence is highest in major cities of the world where poverty and overcrowding are common—as many as 8 in 10 adults are believed to be infected in many of the developing world's poorest and most populous cities.

Cities are also the epicenters of the HIV pandemic.

HIV infection has emerged as the most significant factor associated with progression from latent *M. tuberculosis* infection to active disease. The risk that active TB will develop in a person co-infected with TB and HIV is about 10 percent *per year*, compared to a *lifetime* risk of 10 percent in a person infected only with TB. From a public health perspective, the imposition of the HIV epidemic can have a devastating effect on TB rates in a community. In the United States, once active TB has been excluded, people co-infected with both HIV and *M. tuberculosis* are encouraged to undergo preventive therapy with the drug isoniazid, which has been shown to effectively prevent the development of active TB. HIV-infected persons with active TB must be treated with more costly and more toxic multidrug regimens.

Because *M. tuberculosis* is spread through the air (unlike HIV), people with TB may be infectious to others around them, especially to those with whom they come into close or extended contact. TB is the only major AIDS-related opportunistic infection that can be spread to HIV-negative people, but also is curable as well as preventable. If left untreated for a year, one person with active TB can infect as many as 10 to 15 others. The United Nations AIDS Program (UNAIDS) predicts that worldwide, over the next 3 years, the spread of HIV will result in more than 3 million new TB cases among both HIV-positive and HIV-negative individuals.

This year's annual observance focused worldwide attention on two facts:

• The threat of TB is real.

• A simple, effective strategy that cures TB in only 6 months is available through DOTS (directly observed treatment, short-course).

The theme of World TB Day 1997 was "Use DOTS More Widely." According to GTP, DOTS is equally effective for HIV-infected and uninfected people. Since 1992, increased funding for TB has allowed state and local health departments in the United States to substantially expand the use of DOT to treat active TB.

At CDC, the Division of TB Elimination's primary focus has been on those persons with active TB disease—treating and curing these people and following up on their contacts. However, an estimated 10 to 15 million Americans are infected, and this pool of infected people is the source of many future cases. TB disease may be costly to treat if the individuals are infected with multidrug-resistant TB. Therefore, focused screening and preventive treatment programs for high-risk groups (particularly HIV-infected persons) should be substantially strengthened.

Educational materials on the interaction between TB and HIV are available from various resources through the CDC National AIDS Clearinghouse. The address and telephone number of the Clearinghouse are listed on page 11.

International TB/HIV informational materials are available for purchase from the WHO's Publication Division at 1211 Geneva 27, Switzerland (direct fax, [41 22] 791 4857).

In addition, educational materials on TB for the general public and health care providers in the United States are available from CDC by calling the National Center for HIV, STD, and TB Prevention's Voice Information System at 404-639-1819. ⌘

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• Programs that offer CT nonroutinely to populations with a low prevalence of HIV infection or risk behaviors may expect low acceptance rates.

• Increased emphasis on routinely offered, voluntary CT may enhance acceptance rates.

• Policies that provide strict confidentiality protections and discourage discrimination will promote acceptance.

• Programs that reduce anxiety during pretest counseling and improve client awareness of and access to the benefits of early diagnosis will encourage acceptance.

• The increasing prevalence of prior testing will discourage acceptance.

• Improvements in the perceived quality and convenience of counseling may increase acceptance rates.

• Evaluation of other HIV prevention strategies is needed.

• Potentially conflicting HIV prevention goals must be balanced.

If you have questions about the study, please contact Kathleen Irwin at CDC, Mail Stop E-45; 1600 Clifton Road, N.E.; Atlanta, Georgia 30333; or by telephone at 404-639-6146 (fax 404-639-6118). ⌘

BRTA/LRTA Programs Launch Web Site

The CDC **Business Responds to AIDS** and **Labor Responds to AIDS** Programs (BRTA/LRTA) have established a new World Wide Web site at **http://www.brta-lrta.org**.

The BRTA/LRTA programs help large and small businesses and labor organizations throughout the United States meet the challenges of HIV/AIDS in the workplace and in the community. These programs work in partnership with businesses and labor unions, as well as trade associations, public health departments, AIDS service organizations, and government agencies to promote the development of comprehensive HIV/AIDS education/prevention programs.

This web site gives an overview of the BRTA/LRTA programs and how to access them. The site features statements from business and labor leaders describing their successful programs and also includes real-life scenarios addressing employment-related HIV/AIDS issues. In addition, the site offers timely information and recent publications on issues related to HIV/AIDS in the workplace.

Visitors to the site will find an extensive list of links to related web sites, such as the Social Security Administration, the American Red Cross Workplace HIV/AIDS Education Program, and the NAMES Project AIDS Memorial Quilt Corporate Program. The site also features a "QuickTime" movie of a Business Responds to AIDS television public service announcement and copies of various print ads.

For more information, visit the BRTA/LRTA web site at the address given above or call the CDC Business and Labor Resource Service at the CDC National AIDS Clearinghouse (NAC) at the telephone number shown at right.

More Clearinghouse News: Resource Guides Updated

In conjunction with "Faith Communities Respond to AIDS Strategic Development," a CDC-sponsored meeting held Nov. 20-22 in Atlanta, CDC's National AIDS Clearinghouse (NAC) has revised its resource guide, *Locating Basic Resources on HIV/AIDS and Faith Communities*.

Representatives of various non-mainstream religions assembled at the meeting to tell CDC about their needs and to provide input into CDC's Faith Initiative strategic planning process.

CDC NAC staff originally developed this resource guide in 1993 in support of the Faith Initiative. Part of the *Locating Basic Resources* series that CDC NAC staff produce on a variety of HIV/AIDS-related topics, the guide can assist faith communities involved in HIV/AIDS prevention work by helping staff find relevant information.

The guide includes resources useful to members of Christian as well as non-Christian faiths. Free copies of *HIV/AIDS and Faith Communities* can be ordered from the CDC National AIDS Clearinghouse by calling 1-800-458-5231 and asking for inventory number B538.

New Resource Guide Offers Information on Statistics

Finding HIV/AIDS statistical data is not always easy; this is evident from the fact that 14 percent of the callers to the CDC NAC reference service ask how to locate different kinds of statistics on HIV/AIDS. In response to this ongoing need, CDC NAC staff developed a resource guide, *Locating Basic Resources on HIV/AIDS Statistics*, to help users find the most up-to-date information available. It provides data on where to obtain national, state, and international AIDS statistics and includes a list of journals that often publish articles with statistical information on HIV/AIDS.

AIDS service organizations have many uses for HIV/AIDS statistics. For example, state and local governments often base HIV/AIDS-related funding and legislative decisions on published statistics. HIV/AIDS educators and staff use statistics as part of efforts to increase public awareness about HIV/AIDS or to determine where to target their prevention efforts. Also, researchers and social scientists use statistical data to chart the course of HIV through affected populations.

Locating Basic Resources on HIV/AIDS Statistics can be ordered by requesting CDC NAC inventory number B985.

Guide for Native Americans

Staff from the CDC NAC are working in partnership with the National Native American AIDS Prevention Center (NNAAPC) on the

(See Clearinghouse News, next page)

Questions?
We have answers.

CDC National AIDS Hotline
1-800-342-AIDS (2437)

Spanish Access:
1-800-344-SIDA (7432)

Deaf Access:
1-800-243-7889

CDC National AIDS Clearinghouse
Post Office Box 6003
Rockville, MD 20849-6003

1-800-458-5231

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development of a new resource guide, *HIV/AIDS and Native Americans: A Guide to Selected Resources.*

The new resource guide is the eighth in the Clearinghouse's Resource Guide series. The guides include information drawn from the Resources and Services, Educational Materials, Periodicals, and Funding databases. In addition, they include pertinent Internet information and the full text of relevant materials, such as *Morbidity and Mortality Weekly Report* articles and CDC fact sheets. *HIV/AIDS and Native Americans: A Guide to Selected Resources* will be available in early spring.

Additional Databases Available on the Internet

Users can now search the Clearinghouse's AIDS Daily Summary and Funding databases on line through the CDC NAC Web site (**http://www.cdcnac.org**). The AIDS Daily Summary database provides access to all article summaries included in the daily "news clipping" service provided by CDC NAC. The Funding database lists opportunities available through the federal government, state governments, and private foundations.

The AIDS Clinical Trials Results database is available through the ATIS web site at **http://www.atis.org**. It includes bibliographic references for journal articles presenting the interim or final results of HIV/AIDS-related experimental clinical trials. Most of the clinical trials included in the database are closed to new patient enrollment; some are still in progress and continue to collect data on the enrolled patients.

For additional information on any of these topics, call the CDC National AIDS Clearinghouse at its toll-free number, 1-800-458-5231. ⌘

CDC Faith Initiative Is Featured at Women's Missionary Conference

At the invitation of African Methodist Episcopal (A.M.E.) Bishop Philip R. Cousin, several CDC staff members addressed a Women's Missionary Society Conference on January 18 in Wilmington, Delaware, to discuss HIV/AIDS in the Black community.

CDC participants included Qairo Ali, Faith Coordinator for the CDC Faith Initiative component of the Community Assistance, Planning, and National Partnerships Branch (CAPNPB), DHAP-IRS, and Reverend George LaSure, a Fellow assigned to CAPNPB's Faith Initiative from the Congress of National Black Churches, Inc. (CNBC). The missionary conference is part of a First Episcopal District (A.M.E. Church) "Learning Experience" coordinated by the Church and Dr. Catherine Wilson, the HIV/AIDS Prevention Education Program Coordinator for the district.

The CDC presentation included information about the CDC National AIDS Clearinghouse provided by Beth Westcott, Clearinghouse Resource Librarian; an overview of the CDC Faith Initiative by Qairo Ali; information on the state of the epidemic by Dr. Kim Holding, Epidemic Intelligence Service Fellow in the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention; an update on the partnership between CNBC and CDC by Dr. Alicia Byrd, Director, Theological Education and Leadership Development Project, CNBC; and the charge to the missionaries by the Reverend George LaSure.

This event represents a major step forward in engaging the faith community in an active role in HIV/AIDS prevention activities. For additional information about CDC's Faith Initiative, call Qairo Ali at 404-639-8317. ⌘

More questions?
Other Services:

Business and Labor Resource Service
1-800-458-5231

AIDS Clinical Trials
1-800-TRIALS-A
(1-800-874-2572)

Treatment Information
1-800-HIV-0440
(1-800-448-0440)

Reprints Now Available from *Public Health Reports* Supplement on Behavioral Science

CDC has reprinted a compilation of reports on its HIV-related behavioral science activities that first appeared in *Public Health Reports*, Vol. 111, Supplement 1. Copies of "Behavioral Science in HIV Prevention: Centers for Disease Control and Prevention" are now available from CDC upon request.

To obtain reprints, please contact the Technical Information and Communications Branch, Division of HIV/AIDS Prevention—Intervention Research and Support, by mail at CDC; NCHSTP/DHAP-IRS/TICB, Mail Stop E-49; 1600 Clifton Road, N.E.; Atlanta, Georgia 30333; by telephone at 404-639-2072; or by E-mail at **lec4@cdc. gov**.

Read more about CDC's behavioral science activities on page 14 in the "Reorganization Update—New Focus for Behavioral Branch." ⌘

CDC, HRSA Work to Implement CARE Act Provision

On May 20, President Clinton signed Public Law 104-146, the Ryan White CARE Act Amendments of 1996. Section 8 of this legislation requires that states take administrative or legislative action to require that a good-faith effort be made to notify a spouse of a known HIV-infected or AIDS patient that he or she may have been exposed to HIV and should seek testing.

The statute defines a spouse as "any individual who is the marriage partner of an HIV-infected patient, or who has been the marriage partner of that patient at any time within the 10-year period prior to the diagnosis of HIV infection." Under this section, states that fail to take administrative or legislative action will be ineligible to receive grant funds under Part B of the Ryan White CARE Act, administered by the Health Resources and Services Administration (HRSA). HRSA and CDC are jointly coordinating the implementation of this provision.

In December, CDC mailed to each state information packets that included a certification form for the appropriate state health official to review, sign, and return to CDC no later than February 1. States were asked to include a brief summary of the administrative or legislative actions they have taken, along with plans for additional actions in the future, for requiring or ensuring that a "good-faith effort" is made to notify spouses of known HIV-infected individuals of their exposure and to refer them for testing. These summaries are being reviewed by CDC and HRSA on a state-by-state basis to determine compliance with the statute and/or the need for technical or other assistance in gaining compliance.

States also were informed that anonymous HIV testing does not preclude effective partner or spousal notification. Unless prohibited by state law or regulation, reasonable opportunities to receive HIV-antibody testing services anonymously should continue to be offered, accompanied by appropriate counseling. The availability of such services may encourage some persons at risk for HIV infection, who might otherwise be reluctant to be tested, to seek testing and prevention counseling.

CDC, HRSA, and their prevention partners developed and distributed to the states examples of principles and practices that constitute a good-faith effort to notify spouses of HIV exposure. These examples are prefaced with the reminder that all identifying information regarding HIV-infected patients and spouses must be kept confidential. No personally identifying information shall be disclosed unless required by state law or political subdivision, or unless the individual provides written, voluntary informed consent.

According to CDC and HRSA, examples of good-faith efforts might include the following:

Beginning April 1, everyone diagnosed with AIDS (or HIV infection in states requiring HIV-infection reporting by law or regulation) should be asked if he or she is married or has had a marriage partner in the last 10 years. They must be informed that they should notify their spouse or former spouse(s) of the potential exposure to HIV. Further, reasonable efforts must be made to determine if each HIV-infected person intends to notify his or her spouse (or former spouse[s]) or agrees to have a qualified health care provider notify them. CDC and HRSA recommend that, for those persons who intend to make the notification themselves, culturally competent counseling and educational services should be available on the following issues:

• how to make the notification

The CARE Act is named for teenager Ryan White, who worked until his death to educate the public and increase compassion for people with AIDS.

• how to preserve the confidentiality of both the HIV-infected person and the spouse

• how HIV infection and transmission can be prevented

• how the spouse can access testing, other prevention services, and treatment

States were further advised that they should develop policies for situations involving HIV-infected persons who do not plan to notify their spouses and who refuse health department assistance in doing so. However, notification is not necessary when, in the judgment of public health officials, there has been no sexual exposure of a spouse to a known HIV-infected individual during the relevant time frame. In addition, health departments that document spousal notification policies and practices of public and private health care providers reporting AIDS or HIV that meet state requirements or establish agreements with them for this purpose need not directly contact every HIV-infected individual reported by such providers for purposes of spousal notification.

CDC has created a work group to develop policy guidelines.

For additional information about the law's provisions, contact Mr. Gary West at CDC, 404-639-5200, or Ms. Anita Eichler at HRSA, 301-443-6745. ⌘

New Telephone Numbers

(All numbers are Area Code 404)

Office of the Director, DHAP-IRS	*639-5200*
Behavioral Interventions Research Branch	639-8300
Community Assistance, Planning, and National Partnerships Branch	639-5230
Program Evaluation Research Branch	639-0952
Technical Information and Communications Branch	639-2072
Training and Technical Support Systems Branch	639-2918
Office of the Director, DHAP-SE	*639-0902*
Epidemiology Branch	639-6130
International Activities Branch	639-6100
Prevention Services Research Branch	639-2090
Statistics & Data Management Branch	639-2020
Surveillance Branch	639-2050

NCHSTP Has Workshop at Managed Care Conference

The National Center for HIV, STD, and TB Prevention sponsored a workshop, "Communicable Disease Control in a Managed Care Environment," at the national managed care conference January 15-16, hosted in Atlanta by CDC and other governmental and nongovernmental agencies. In an HIV case study, workshop participants addressed the expectations that public health and managed care plan officials have of each other when an HMO identifies an HIV-infected pregnant woman and the barriers to collaboration in this situation. Use of the case study was successful in engaging participants in exploring respective roles and identifying unresolved issues for further discussion.

Inquiries about the Divisions' managed care projects should be addressed to Kathy Rauch, telephone 404-639-0902; fax 404-639-0910; or E-mail, **kjr1@cdc.gov.** ⌘

Reorganization Update

New Focus for Behavioral Branch

This issue features the Behavioral Intervention Research Branch (BIRB) in the Division of HIV/AIDS Prevention—Intervention Research and Support (DHAP-IRS). The branch was created in 1995 out of the Behavioral and Prevention Research Branch of the former Division of STD/HIV Prevention during the reorganization of CDC's HIV/AIDS prevention activities.

BIRB's new research projects focus on some of the groups at highest risk of acquiring or transmitting HIV infection. BIRB also is supporting new projects that address translating research findings into practice.

BIRB collaborates with federal, state, and local HIV prevention partners in identifying research priorities and designing intervention research. The identification of research priorities is guided by the epidemiology of HIV/AIDS. BIRB then applies current theory, practice, and empirical findings in designing and conducting research on state-of the-art behavioral interventions to prevent HIV infection in identified priority groups. Finally, research findings are disseminated through publications and presentations.

New Research Projects

Two new cooperative agreements are targeting behavioral intervention research toward groups at high risk.

One of the new studies, *Youth at Risk: Developing Community-level Interventions that Work*, will be conducted in New York City by researchers from the Education Development Center, in Milwaukee and Detroit by researchers from the Medical College of Wisconsin's Center for AIDS Intervention Research (CAIR), in San Francisco by researchers from the University of California—San Francisco's Center for AIDS Prevention Studies (CAPS), in Chicago by researchers from the University of Illinois, and in Minneapolis and Los Angeles by researchers from the University of Minnesota. This 5-year study targets young men representing various races/ethnicities (African American, Hispanic, Asian/Pacific Islander, White) who have sex with other men, and will be undertaken in collaboration with local community-based organizations that have experience with these populations.

Epidemiological surveillance has shown that high HIV prevalence exists among men who have sex with men (MSM) and it is increasing in minority populations and among youth. In addition, few programs serve young MSM. The project investigators first will conduct formative research to determine constraints and opportunities for behavior change in these populations. Second, they will identify components of an intervention that likely will be acceptable, sustainable, and effective in changing norms, attitudes, and behaviors. Third, each research project will develop a community mobilization plan that links young MSM with HIV prevention and support services. Last, they will develop and pilot-test a developmentally and culturally appropriate intervention.

Another project, *Formative Behavioral Intervention Research on the Prevention of Sexual Transmission of HIV by HIV-Seropositive Men*, will be conducted by researchers working in collaboration with local community-based organizations that have experience with these populations. The project will be conducted in New York City by researchers from Jersey City College and Rutgers University and in San Francisco by researchers from CAPS.

(See BIRB, next page)

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This 2-year research project focuses on men who know they are infected with HIV and who also have sex with other men. This group's risky sex practices potentially can spread HIV infection in a population already disproportionately affected by the disease.

Formative research during the first phase of this project will identify barriers and facilitators of safer sex practices and other factors associated with the risk of sexual HIV transmission and serostatus disclosure by such men. During the second phase, the researchers will develop an intervention model based on the first-phase data and behavioral theory and will pilot-test it to ascertain its feasibility and acceptability to HIV-positive men. Following the pilot-test, the model will be evaluated further in a controlled study to determine its effectiveness in encouraging behavior change.

Previous research has not addressed the difficult question of how programs actually implement findings from behavioral research. Therefore, BIRB is examining the processes and factors that influence the translation, diffusion, and sustainability of behavioral intervention research findings to HIV prevention programs.

A new branch project concentrating on bridging research and application is *Replication of Effective HIV Behavioral Interventions.* This cooperative agreement has been awarded to replicate interventions that were proven through scientific evaluation to be effective in changing behavior.

During the next 2 years, each of four research institutions will replicate an effective behavior-change intervention to make it available to other HIV prevention programs, learn about the process these programs go through in starting up a new intervention, and help the programs find ways to keep the intervention running after the end of this project. The Education Development Center is replicating an intervention for STD, HIV, and family planning clinic settings in Massachusetts that involves viewing a video followed by group discussion to promote condom use among African-American and Hispanic clients. The Family Health Council's intervention will allow collaborating community-based organizations and public housing communities in Pittsburgh to use counseling and street outreach in a peer-led effort to prevent HIV infection among women in their community. The Medical College of Wisconsin's CAIR will work with AIDS service organizations in Milwaukee to develop a "popular opinion leader" community-level intervention to prevent HIV transmission among MSM. The CAPS will disseminate the *Mpowerment Project* in targeted San Francisco communities to reduce the frequency of unprotected anal intercourse among young MSM.

One of BIRB's most important new initiatives addresses the strategies used by HIV prevention programs. *Cumulative Research Synthesis System for HIV/AIDS Behavioral and Social Science Intervention Studies* is a contract awarded to Aspen Systems Corporation of Rockville, Maryland. During the next 3 years, the project will conduct a systematic review of existing behavioral intervention research studies, establish a system of organizing the information in a quantitative database, and analyze the accumulated information. The system will lead to the identification of interventions that have been proven scientifically to be effective in changing HIV-related risk behaviors, as well as areas that require further study. It also will suggest ways to improve the quality of new behavioral intervention research studies.

Completed intervention research should be fully analyzed so the findings can be better utilized by HIV prevention programs. *Follow-up or Secondary Analysis of HIV Behavioral Intervention Research Studies* is the new branch project that addresses this issue. One-year grants have been awarded to Battelle Memorial Institute of Seattle; Family Health Council, Inc., of Pittsburgh; Medical College of Wisconsin's CAIR at Milwaukee; Philadelphia Health Management Corporation; Research Foundation for Mental Hygiene of New York City; San Diego State University Foundation; and the CAPS. The grantees will conduct follow-up or secondary analysis of existing HIV behavioral intervention data sets. These grants will provide important information to prevention programs through more in-depth analyses of data from effective interventions.

BIRB anticipates conducting additional new research targeted to groups at high risk for infection and continuing work with other CDC branches in disseminating interventions and research findings to CDC-funded HIV prevention programs. For more information on BIRB projects, contact Bob Kohmescher at CDC, telephone 404-639-8300 or E-mail **rnk1@cdc.gov**. ⌘

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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